1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2680

CERTIFICATE OF DEATH

02623

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 2 Yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Rt # 4

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Salisbury
d. STREET ADDRESS: 1 Rt # 4
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ELIN — Middle BOLLIN — Last BARR

4. DATE OF DEATH: Month 2 — Day 20 — Year 1960

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Jan. 13, 1871
9. AGE (In years last birthday): 89 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Sweden
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Bollin
14. MOTHER'S MAIDEN NAME: Edla Gavurri

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): *****
16. SOCIAL SECURITY NO.: None
17. INFORMANT — Address: Mr. Robert Barr, Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Accident — INTERVAL BETWEEN ONSET AND DEATH: 1 wk

4427 DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Hypertensive Cardio-Vascular renal disease — many years

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 1, 1959 to Feb 19, 1960 that I last saw the deceased alive on 2/19/60, 19____, and that death occurred at 1:00 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Paul Green M.D. — ADDRESS (Street, city or town, state): Snow Hill Md — DATE SIGNED: 2/22/60

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/23/60
22c. NAME OF CEMETERY OR CREMATORY: Mt. Moriah Cemetery
22d. LOCATION (City, town, or county) (State): Phila. Pa.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Hill & Johnson Co. Salisbury, MAryland

24a. REC'D BY REGISTRAR DATE: FEB 24 '60
24b. REGISTRAR'S SIGNATURE: Clinton L. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02624

2634

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH

COUNTY Wicomico — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury

LENGTH OF STAY (in this place) since 1/12/60

HOSPITAL OR INSTITUTION OR STREET ADDRESS Pine Bluff State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY Dorchester

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge 0913.2

STREET ADDRESS (If rural give location) 111 Muse St.

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) AMANDA ANGELINE BLADES

4. DATE OF DEATH (Month) (Day) (Year) Feb. 21 1960

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
F	W	Widow	August 27, 1880	79 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Home	Maryland	U.S.A.

13. FATHER'S NAME Charles Evans Hughes

14. MOTHER'S MAIDEN NAME Frances Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
No	None	Records of Pine Bluff State Hosp.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

002X IMMEDIATE CAUSE (A) Pulmonary tuberculosis — INTERVAL BETWEEN ONSET AND DEATH: 2 mos.

ANTECEDENT CAUSE(S) DUE TO (B)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19e. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/12, 1960, to 2/21, 1960, that I last saw the deceased alive on 2/20, 1960, and that death occurred at 9:30A.M, from the causes and on the date stated above.

SIGNATURE Edward P. Ritchings M.D. **ADDRESS** (Street, city, town, state) Pine Bluff State Hosp., Salisbury, Md. **DATE SIGNED** 2/21/60

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
	2-23-60	Dorchester Memorial	Cambridge Md

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
FEB 23 '60	Catina L. Kraus	Kenneth R. Thomas	Cambridge Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2635

CERTIFICATE OF DEATH

02625 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Wicomico MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town) Salisbury
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION 927 Brown St

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Wicomico
c. CITY OR TOWN (If outside corporote limits, write RURAL ond give nearest town) 12 Salisbury
d. STREET ADDRESS 927 Brown St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First MATTIE Middle VIRGINIA Last BOUNDS
4. DATE OF DEATH Month February Day 8th Year 1960
5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH June 6,1906
9. AGE (In years last birthday) 53 yrs.
IF UNDER 1 YEAR Months 8 Days 2 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Former Employee-Shirt Factory
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Ocean City, Maryland
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME Clarence W. Hastings
14. MOTHER'S MAIDEN NAME Annie L. Truitt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
INFORMANT Mrs. Norma Lee Ellis (Sister) Address 927 Brown St Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Metastatic CA of Liver — INTERVAL BETWEEN ONSET AND DEATH 1 yr
152.0
DUE TO (b) Ca of Duodenum — 3 yrs
Conditions, if any, which gove rise to immediate couse (o), stoting the underlying couse last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ____, 1957 to Feb 8, 1960, that I last saw the deceased alive on Feb 8, 1960, and that death occurred at 1:20P M, from the causes and on the date stated above.

ACTUAL SIGNATURE William D Gray M.D. ADDRESS (Street, city or town, state) 334 Camden Ave DATE SIGNED Feb. 9th /1960

PHYSICIAN'S NAME (Type) Dr. William D. Gray Camden Ave. Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF Feb. 11, 1960
22c. NAME OF CEMETERY OR CREMATORY Allen Church Cemetery
22d. LOCATION (City, town, or county) (State) Allen, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS HOLLOWAY & COMPANY SALISBURY MARYLAND
24a. REC'D BY REGISTRAR DATE FEB 10 '60
24b. REGISTRAR'S SIGNATURE Alvin L. Travers

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2651

02626

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): (Rural) Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: R.D.# 3(Gumboro Rd)

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Salisbury (Rural)
d. STREET ADDRESS: R.D.# 3 (Gumboro Rd)
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EVA — Middle KATHERINE — Last BOWER

4. DATE OF DEATH: Month FEBRUARY — Day 22 — Year 1960

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: January 27,1887
9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months 0 — Days 23
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Penna.(Lockhaven)
12. CITIZEN OF WHAT COUNTRY?: U S A

13. FATHER'S NAME: Francis Bowling
14. MOTHER'S MAIDEN NAME: Frances Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mr.George W.Bower(Son) Address: R.D.#(Tony Tank) Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Cerebral Hemorrhage	38 hours
DUE TO		
331 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	cerebral arteriosclerosis	Indef.
DUE TO (c)	generalized arteriosclerosis	Indef.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Cerebral Thrombosis — April 1959

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from February 21, 1960, to February 23, 1960, that I last saw the deceased alive on February 21, 1960, and that death occurred at 2:10 P. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert J. Adkins M.D.
ADDRESS (Street, city or town, state): Fruitland, Maryland
DATE SIGNED: Feb. 24/1960

PHYSICIAN'S NAME (Type): Dr. Robert Adkins

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	Feb.25,1960	Wicomico Memorial Park	Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
HOLLOWAY & COMPANY SALISBURY MARYLAND	FEB 26 '60	Arthur S. Krauss

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2636

CERTIFICATE OF DEATH

02627 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 50 Yrs.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Wiocmico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury
d. STREET ADDRESS: 713 Camden Ave.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 713 Camden Ave.,

3. NAME OF DECEASED (Type or print): First DIADEMMA Middle McGRATH Last BREWINGTON

4. DATE OF DEATH: Month 2 Day 9 Year 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Mar. 29,1871

9. AGE (In years last birthday): 88 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Josiah McGrath

14. MOTHER'S MAIDEN NAME: Elinora Robertson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs. Marhta B. Harrington, Same — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 6 mos.
DUE TO (b): generalized arteriosclerosis — 10 yr.
DUE TO (c):

332 ×

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Mar, 1956 to 2/8/, 1960, that I last saw the deceased alive on 2/8, 1960, and that death occurred at 6 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Earl Beardsley, M.D. — ADDRESS (Street, city or town, state): Salisbury, Maryland — DATE SIGNED: 2/11/60

PHYSICIAN'S NAME (Type): Dr. Earl Beardsly 207 Maryland Ave., Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2/11/1960

22c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery

22d. LOCATION (City, town, or county) (State): Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Hill & Johnson Co. Salisbury, Maryland

24a. REC'D BY REGISTRAR DATE: FEB 15 '60

24b. REGISTRAR'S SIGNATURE: Cicilian S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2682

CERTIFICATE OF DEATH

02628

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sharptown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: R.F.D.1 Sharptown Maryland

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Sharptown
d. STREET ADDRESS: R.F.D.1 Sharptown Maryland
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Amy — Middle: Ellen F. — Last: Brown

4. DATE OF DEATH: Month: Febuary — Day: 24 — Year: 1960

5. SEX: Female

6. COLOR OR RACE: C.

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: April 6,1892

9. AGE (In years lost birthday): 67 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Jones

14. MOTHER'S MAIDEN NAME: Anna Hopkins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Address: Cora Brown R.F.D. 1 Mardela Springs Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Ca Carcinoma Gall Bladder — INTERVAL BETWEEN ONSET AND DEATH: 2 years
155.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Cardiac Lesion - Valvular.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: o. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Apr, 1959, to Feb 24, 1960, that I last saw the deceased alive on Febr 23, 1960, and that death occurred at 4:4 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: H S Kuhlman M.D.
ADDRESS (Street, city or town, state): Sharptown Md
DATE SIGNED: 2/27/60
PHYSICIAN'S NAME (Type): H. S. Kuhlman

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2 27 /60
22c. NAME OF CEMETERY OR CREMATORY: Sharptown
22d. LOCATION (City, town, or county) (State): Sharptown Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Clinton F. Stewart
ADDRESS: Salisbury Md
24a. REC'D BY REGISTRAR DATE: MAR 1 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Travers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2693 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 02629

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): R.D.# 5 Schumaker Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Salisbury
d. STREET ADDRESS: R.D.# 5 Schumaker Rd
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First JOHN — Middle THOMAS — Last CAREY

4. DATE OF DEATH: Month February — Day 28th — Year 19 60

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: Aug. 24, 1891

9. AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR: Months 6 — Days 4
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Wicomico Co. Maryland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: James Henry Carey

14. MOTHER'S MAIDEN NAME: Margaret Jane Twigg

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Ada D. Carey (Wife) Address: R.D.#5 Schumaker Rd Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Congestive Failure — INTERVAL BETWEEN ONSET AND DEATH: hours
DUE TO (b): Myocardial Degeneration — 2 yrs
DUE TO (c):

422.2
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy [ ], Inspection [X], Inquiry [X], and find that death resulted from: Noturol couses [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined cause [ ].

ACTUAL SIGNATURE: Earl L. Royer M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

EXAMINER'S NAME (Type): Dr. Earl L. Royer

DATE SIGNED: March 1 /1960

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Mar. 2, 1960
22c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park
22d. LOCATION (City, town, or county) (State): Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: HOLLOWAY & COMPANY
ADDRESS: SALISBURY, MARYLAND

24a. REC'D BY REGISTRAR DATE: MAR 2 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Evans

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2694 **CERTIFICATE OF DEATH** Reg. Dist. No. 2630

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL DELMAR
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Route # 3

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Delmar - Rural
d. STREET ADDRESS: Route # 3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First HAZEL Middle B. Last Church

4. DATE OF DEATH: Month 2 Day 17 Year 1960

5. SEX: F M.

6. COLOR OR RACE: A A.

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3-29-1910

9. AGE (In years last birthday): 49 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Delaware

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Arthur Burris

14. MOTHER'S MAIDEN NAME: Annie Johnson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — Address: MR. Harry Church - Rt # 3, Delmar, Del

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of Breast with generalized metastasis (Carcinoma simplex)
DUE TO
(b):
DUE TO
(c):

170 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 3 Yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 4/27, 1954, to death, 19____, that I last saw the deceased alive on 2/15/, 1960, and that death occurred at 9 P.M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Ernest Larmore M.D.

ADDRESS (Street, city or town, state): 100 Grove Street

DATE SIGNED:

PHYSICIAN'S NAME (Type): Ernest M. Larmore — Delmar, Delaware

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2-20-60

22c. NAME OF CEMETERY OR CREMATORY: Green Acre Mem. Park

22d. LOCATION (City, town, or county) (State): Salisbury Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Thornton B. Jolley

ADDRESS: Salisbury, Md.

24a. REC'D BY REGISTRAR DATE: FEB 29 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Mears

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2631 — 02631 — Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 37RS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: N. PARK GARDENS

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury
d. STREET ADDRESS: Glen & Longs Aves
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Aince — Middle: Louise — Last: Cruse

4. DATE OF DEATH: Month: 2 — Day: 18 — Year: 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12-23-1890

9. AGE (In years last birthday): 69 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: John B. Keplinger

14. MOTHER'S MAIDEN NAME: MAY ELLEN WILCOX

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: ROBERT L. CRUSE — Address: SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion
DUE TO (b): Coronary Arteriosclerosis — 6 mos.
DUE TO (c):

420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: White at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 20, 1957, to Feb 18, 1960, that I last saw the deceased alive on Feb 15, 1960, and that death occurred at 4:00 A. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Thomas C. Hill Jr., M.D. — ADDRESS (Street, city or town, state): Pine Bluff Road — DATE SIGNED: 2/19/60

PHYSICIAN'S NAME (Type): THOMAS C. HILL — Salisbury Md

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — 22b. DATE THEREOF: 2/20/1960 — 22c. NAME OF CEMETERY OR CREMATORY: LOUDEN PARK — 22d. LOCATION (City, town, or county) (State): BALTIMORE, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: HILL & JOHNSON Co. — ADDRESS: Salisbury, Md.

24a. REC'D BY REGISTRAR DATE: FEB 23 '60 — 24b. REGISTRAR'S SIGNATURE: Arthur S. Travis

George C. Hill II

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2638 **CERTIFICATE OF DEATH** 12632

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 30 Yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 510 Truitt St.,

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury
d. STREET ADDRESS: Truitt St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First BESSIE Middle CALLOWAY Last CULVER

4. DATE OF DEATH: Month 2 Day 24 Year 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11-11-1892

9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William F. Calloway

14. MOTHER'S MAIDEN NAME: Elizabeth Wingate

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ***

16. SOCIAL SECURITY NO.: 214-10-7853

17. INFORMANT: J. Craig Culver, Same — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Suspicion — INTERVAL BETWEEN ONSET AND DEATH: 2 mo

DUE TO (b) Progressive Anemia — 6 mo

DUE TO (c) Stomach Carcinoma — 3 yrs

151X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1959, to 2-24, 1960, that I last saw the deceased alive on 2-23, 1960, and that death occurred at 10:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: W B Smith M.D. ADDRESS (Street, city or town, state): Salisbury, Maryland DATE SIGNED: 2-26-60

PHYSICIAN'S NAME (Type): Dr. William B. Smith, Medical Ceneter Salisbury, Marykand

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2-28-60

22c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery

22d. LOCATION (City, town, or county) (State): Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Hill & Johnson Co. Salisbury, Maryland

24a. REC'D BY REGISTRAR DATE: FEB 29 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

Frankland & Hill

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2639

CERTIFICATE OF DEATH

Reg. Dist. No. 02633

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 1285 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen 1231.2
d. STREET ADDRESS: Bush Chapel Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Isiah; Middle: Rodgers; Last: Davis

4. DATE OF DEATH: Month: 2; Day: 21; Year: 1960

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

9. AGE (In years last birthday): 47 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Sanitation Dept.

11. BIRTHPLACE (State or foreign country): Virginia ?

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edward Isiah Davis

14. MOTHER'S MAIDEN NAME: Mary ? Morton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown (If yes, give war or dates of service): No —

16. SOCIAL SECURITY NO.: 218-05-1722

INFORMANT: Deer's Head Records Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Aspiration pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 5 days

DUE TO

355X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Progressive cerebellar degenerative disease — Years

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Port II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Manth, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8/15, 19 56 to 2/21, 1960, that I last saw the deceased alive on 2/21, 19 60, and that death occurred at 12:40 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: V. Juerman M.D.

ADDRESS (Street, city or town, state): Deer's Head State Hospital

DATE SIGNED: 2/22/60

PHYSICIAN'S NAME (Type): V. Juerman, M. D. Salisbury, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2-27-1960

22c. NAME OF CEMETERY OR CREMATORY: Mt. Calvary Cemetery

22d. LOCATION (City, town, or county) (State): Aberdeen, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Otis J. Bullock, Havre de Grace Md.

24a. REC'D BY REGISTRAR DATE: FEB 26 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2695 Reg. Dist. No. 02634

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland b. COUNTY: Wicomico

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Willards Rural
c. LENGTH OF STAY IN 1b: Life

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Willards

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: XXX

d. STREET ADDRESS: RRD

e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First IDA Middle MAE Last DENNIS

4. DATE OF DEATH: Month Feb. Day 26, Year 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: Sept. 9, 1876

9. AGE (In years last birthday): 83 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Handy Littleton

14. MOTHER'S MAIDEN NAME: Elizabeth Truitt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): XX (If yes, give war or dates of service): XX

16. SOCIAL SECURITY NO.: XX

17. INFORMANT: Mrs. James Fisher Address: Willards, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Myocarditis Chronic — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs.
443X
DUE TO
(b): Hypertension — 15 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m.

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1945, 19____, to 2-26-, 1960, that I last saw the deceased alive on 2-25-1960, 19____, and that death occurred at 8:40 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Frank Lewis M.D. ADDRESS (Street, city or town, state): Willards Maryland DATE SIGNED:

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2/28/60

22c. NAME OF CEMETERY OR CREMATORY: Mt. Pleasant

22d. LOCATION (City, town, or county): Willards (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Peter Whaley ADDRESS: Selbyville Del

24a. REC'D BY REGISTRAR DATE: FEB 29 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02635

CERTIFICATE OF DEATH

2640

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Berlin — 23X-2
d. STREET ADDRESS: Branch Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Inf- Middle: — Last: Derrickson

4. DATE OF DEATH: Month: February Day: 27 Year: 1960

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: February 27-1960

9. AGE (In years last birthday) ___ yrs. IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours 2 Min. 20

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Pen Gen Hosp

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Monsfield Derrickson

14. MOTHER'S MAIDEN NAME: Barbra Conway

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: none

INFORMANT: Monsfield Derrickson — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Immaturity (Birthwt 5 oz gms)
DUE TO
(b):
DUE TO
(c):

776X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/27, 1960, to 3/27, 1960, that I last saw the deceased alive on 2/27, 1960, and that death occurred at 5:40 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Alfred C Kolb M.D.

ADDRESS (Street, city or town, state): Medical Center Salisbury, Maryland

DATE SIGNED: 3/1/60

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3-1-60

22c. NAME OF CEMETERY OR CREMATORY: Evergreen Cem

22d. LOCATION (City, town, or county) (State): Berlin Md

23. FUNERAL DIRECTOR'S SIGNATURE: Parker M West — ADDRESS:

24a. REC'D BY REGISTRAR DATE: MAR 7 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Russell

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

2082-261XVO

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02636

2641 **CERTIFICATE OF DEATH**

Reg. Dist. No.

1. **PLACE OF DEATH** a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke 23422
d. STREET ADDRESS: 512 BANKS ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Idell Middle: Last: Dickerson

4. **DATE OF DEATH**: Month: February Day: 6 Year: 1960

5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Feb. 6, 1884
9. AGE (In years last birthday): 75 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): DOMESTIC
10b. KIND OF BUSINESS OR INDUSTRY: HOUSEWORK
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George Anderson
14. MOTHER'S MAIDEN NAME: Jane ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
INFORMANT: Robert Dickerson Address: Pocomoke, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 week
332X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from _____, 19____, to 2-6, 1960, that I last saw the deceased alive on 2-6, 1960, and that death occurred at 6 30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Willard R. Eddis M.D. ADDRESS (Street, city or town, state): Salisbury, Md. DATE SIGNED: 2-6-60

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-11-60
22c. NAME OF CEMETERY OR CREMATORY: Halls Hill
22d. LOCATION (City, town, or county) (State): Pocomoke, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Edgar Wharton - New Church, Va.
24a. REC'D BY REGISTRAR DATE: FEB 15 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Travers

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02637

2642

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
c. LENGTH OF STAY IN 1b 4 WKS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland — b. COUNTY Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Eden
d. STREET ADDRESS Route # 2
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print) First: WARREN Middle: T. Last: Dorman

4. DATE OF DEATH Month: February Day: 19 Year: 1960

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 3-15-1882

9. AGE (In years last birthday) 77 yrs.
IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER

10b. KIND OF BUSINESS OR INDUSTRY: FARM

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas Jones

14. MOTHER'S MAIDEN NAME: Mary Dorman

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

INFORMANT Address: Warren Dorman, Salisbury Md. Rt #1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 443 Cerebro Vascular Accident
DUE TO
(b) Senility
DUE TO
(c) Hypertensive C.V.I Disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. / p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2-1, 1960, to 2-19, 1960, that I last saw the deceased alive on 2-19, 1960, and that death occurred at 1:00 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Wm B Smith M.D. — ADDRESS (Street, city or town, state): Med. Center Dr. William B. Smith, Salisbury, Md. — DATE SIGNED: 2/24/60

PHYSICIAN'S NAME (Type) DR. WILLIAM B. SMITH
The Medical Center
Rt. 2, Salisbury, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF 2-21-60

22c. NAME OF CEMETERY OR CREMATORY Friendship Cem.

22d. LOCATION (City, town, or county) (State) Allen, Md.

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Thornton B. Jolley, Salisbury Md.

24a. REC'D BY REGISTRAR DATE FEB 29 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2643

CERTIFICATE OF DEATH

02638

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 158 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Queen Anne's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Centreville
d. STREET ADDRESS: 310 Little Kidwell
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

17X-2

091

3. NAME OF DECEASED (Type or print): First: Eva; Middle: ; Last: Dorsey

4. DATE OF DEATH: Month: February; Day: 29; Year: 19 60

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 5/17/1887

9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months ; Days ; IF UNDER 24 HRS.: Hours ; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: Housework

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Wilson

14. MOTHER'S MAIDEN NAME: Annie Trusty

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unk. (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: NONE

INFORMANT: Deer's Head Hospital Records (Address)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Thrombosis of right coronary artery — INTERVAL BETWEEN ONSET AND DEATH: 8 hrs
420.1
DUE TO
(b): Arteriosclerosis, general — Years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Trachea-bronchitis

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept. 24, 1959, to Feb. 29, 1960, that I last saw the deceased alive on February 29, 1960, and that death occurred at 11:25 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: V. Juerman. M.D.
ADDRESS (Street, city or town, state): Deer's Head State Hospital
DATE SIGNED: 3/1/60

PHYSICIAN'S NAME (Type): V. Juerman, M. D.
Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: March 4-1960
22c. NAME OF CEMETERY OR CREMATORY: Chesterfield
22d. LOCATION (City, town, or county) (State): Centreville Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Howard Baxter of Baxter Bros
ADDRESS: Cambridge Md

24a. REC'D BY REGISTRAR DATE: MAR 3 '60
24b. REGISTRAR'S SIGNATURE: [illegible] S. Truma

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02639

CERTIFICATE OF DEATH

2644

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: WICOMICO — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: PENINSULA GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WORCESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OCEAN CITY
d. STREET ADDRESS: BALTIMORE AVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

23X-2

082

3. NAME OF DECEASED (Type or print): First KURT — Middle — Last DOSE

4. DATE OF DEATH: Month FEBRUARY — Day 15 — Year 1960

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: MAY 10, 1908
9. AGE (In years last birthday): 51 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MANUFACTURER
10b. KIND OF BUSINESS OR INDUSTRY: CANDY
11. BIRTHPLACE (State or foreign country): BREMEN GERMANY
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLY DOSE
14. MOTHER'S MAIDEN NAME: ERNA BORGSTADT

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WORLD W. 2
16. SOCIAL SECURITY NO. 262-22-0027
INFORMANT Address: MR. SAM TAUSTIN, OCEAN CITY, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
Immediate cause (a): Acute hemorrhagic pancreatitis
584X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): chronic cholecystitis & stones
DUE TO (c): Choledocholithiasis
INTERVAL BETWEEN ONSET AND DEATH: 48 hrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 19 — Hour o. m. p. m.
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/12/, 1960, to 2/15/, 1960 that I last saw the deceased alive on 2/14/, 1960, and that death occurred at 12:55 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: William H. Fisher Jr. M.D.
ADDRESS (Street, city or town, state): Salisbury Md.
DATE SIGNED: 2-15-60

PHYSICIAN'S NAME (Type)

22a. ~~BURIAL~~, CREMATION, ~~REMOVAL (Specify)~~: Cremation
22b. DATE THEREOF: 2/17/60
22c. NAME OF ~~CEMETERY~~ OR CREMATORY: SILVERBROOK.
22d. LOCATION (City, town, or county) (State): WILMINGTON DEL.

23. FUNERAL DIRECTOR'S SIGNATURE: James A. Bunbage
ADDRESS: Berlin Md
24a. REC'D BY REGISTRAR DATE: FEB 18 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2645 Item 8 FilmG258 3-15-60 et

CERTIFICATE OF DEATH

02640 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Peninsula General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Princess Anne
d. STREET ADDRESS: Somerset Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Breddelle Middle H. Last Dougherty

4. DATE OF DEATH: Month February Day 25 Year 1960

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Oct 26 1882
9. AGE (In years lost birthday): 77 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Md.
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Zadoc Dougherty
14. MOTHER'S MAIDEN NAME: Adelia Henry

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
INFORMANT: Mrs. Breddelle Dougherty Address: Princess Anne

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarct — INTERVAL BETWEEN ONSET AND DEATH: 5 hrs.
DUE TO (b): Hypertension — 3 yrs.
DUE TO (c):

Conditions, if any, which gave rise to immediate couse (a), stoting the underlying couse lost. 420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb 24, 1960, to Feb 25, 1960, that I last saw the deceased alive on Feb 25, 1960, and that death occurred at 11:55 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: B. Frank Gigante M.D. ADDRESS (Street, city or town, state): 20 Prince William St. Princess Anne Md DATE SIGNED: 2/25/60

PHYSICIAN'S NAME (Type): B. FRANK GIGANTI

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/27/60
22c. NAME OF CEMETERY OR CREMATORY: Manokin
22d. LOCATION (City, town, or county) (State): Princess Anne Md

23. FUNERAL DIRECTOR'S SIGNATURE: Homer Hickman ADDRESS: Princess Anne Md
24c. REC'D BY REGISTRAR DATE: MAR 3 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Evans

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

2646

Reg. Dist. No. 02641

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke, md. - 2342.2
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

082

3. NAME OF DECEASED (Type or print): First: Chancey — Middle: — Last: Doughty

4. DATE OF DEATH: Month: February — Day: 2, — Year: 1960.

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec. 31 1959

9. AGE (In years last birthday) yrs. — IF UNDER 1 YEAR: Months: 1 Days: 2 — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY: Infant

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Chancey Doughty

14. MOTHER'S MAIDEN NAME: Vivian Conquest

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: —

INFORMANT: Chancey Doughty — Address: Pocomoke, md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Gangrene Small Intestine & Peritonitis — INTERVAL BETWEEN ONSET AND DEATH: approx 44 hrs
570.3
DUE TO (b): Mid-gut volvulus
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/1, 19 60 to 2/2, 19 60, that I last saw the deceased alive on 2/2, 19 60, and that death occurred at 4 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Alfred C. Koll, M.D. — ADDRESS (Street, city or town, state): Medical Center — DATE SIGNED: 2/3/60

PHYSICIAN'S NAME (Type): Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 2-4-60 — 22c. NAME OF CEMETERY OR CREMATORY: Burton — 22d. LOCATION (City, town, or county) (State): Locustville, Va.

23. FUNERAL DIRECTOR'S SIGNATURE: Edgar Wharton — ADDRESS: New Church, Va.

24a. REC'D BY REGISTRAR DATE: FEB 8 '60 — 24b. REGISTRAR'S SIGNATURE: Carlton E. Tilman

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

9VVVVVVXVV

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2647

CERTIFICATE OF DEATH

02642

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL ond give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 82 days
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION: Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Somerset
c. CITY OR TOWN (If outside corporote limits, write RURAL ond give nearest town): Westover 19x-2
d. STREET ADDRESS: RFD # 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

091

3. NAME OF DECEASED (Type or print): First: Mary; Middle: C; Last: Ennis

4. DATE OF DEATH: Month: February; Day: 2; Year: 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 10/19/1876

9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months; Doys
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Housework

11. BIRTHPLACE (Stote or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Ferdnand Steiger

14. MOTHER'S MAIDEN NAME: Caroline Steigler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unk.
(If yes, give war or dates of service): --

16. SOCIAL SECURITY NO.: None

INFORMANT: Deer's Head Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Nephrosclerosis arteriolar — INTERVAL BETWEEN ONSET AND DEATH: ?
446x
DUE TO
Conditions, if ony, which gove rise to immediate couse (o), stoting the underlying couse lost.
(b) Arteriosclerosis, general — ?
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o): Diabetes mellitus and arteriosclerotic cardiovascular disease

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Doy, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (Stote)

21. I certify that I attended the deceased from Nov. 12, 1959, to Feb. 2, 1960, that I last saw the deceased alive on February 2, 1960, and that death occurred at 9:50 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: V. Juerman — M.D. — ADDRESS (Street, city or town, stote): Deer's Head State Hospital — DATE SIGNED: 2/2/60

PHYSICIAN'S NAME (Type): V. Juerman, M. D. — Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2-5-60

22c. NAME OF CEMETERY: Rehobeth Presbyterian

22d. LOCATION (City, town, or county) (Stote): Rehobeth, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Henry H. Watson — ADDRESS: Pocomoke City, Md.

24a. REC'D BY REGISTRAR — DATE: FEB 8 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG256 2-18-60 et

02643

2648

CERTIFICATE OF DEATH

Reg. Dist. No.

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY: Wicomico — MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury c. LENGTH OF STAY IN 1b: 22 Yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 422 Pinehurst	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury d. STREET ADDRESS: 422 Pinehurst e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
NORMAN	PERCY	FOSTER	2	4	1960

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White		Dec. 11, Approx.	75 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Ret. U.S. Gov. Dept. Health Educ.& Welfare		Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Percy Foster	Louise Wescott

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
Yes.	W.W.I		Mrs. Hazel Foster,	Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 5 min.

420.1

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b): Generalized arteriosclerosis

DUE TO

(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ~, 19____, to ~, 19____, that I last saw the deceased alive on ~, 19____, and that death occurred at 9:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: H.F. Briele M.D. — ADDRESS (Street, city or town, state): Medical Center — DATE SIGNED: 2-6-60

PHYSICIAN'S NAME (Type): H. F. Briele — Salisbury, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	2/7/1960	Parsons Cemetery	Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Hill & Johnson Co. Salisbury, Maryland	FEB 10 '60	Arthur S. Kraus

VS A1S (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2649 **CERTIFICATE OF DEATH** Reg. Dist. No. 02644

1. **PLACE OF DEATH**
a. COUNTY: WICOMICO — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: PENINSULA GENERAL HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: Md. b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ocean City 23x-2
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print): First MARY Middle AGNES Last FOTHERGILL

4. **DATE OF DEATH**: Month 2 Day 14 Year 1960

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: FEBRUARY 8, 1960

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months Days 6 — IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): SALISBURY MD

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN S. FOTHERGILL

14. MOTHER'S MAIDEN NAME: MARGARET ELLIOTT

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): — (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: —

INFORMANT Address: MR. JOHN S. FOTHERGILL

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 773.5 Respiratory Failure
DUE TO
(b): Prematurity - 700 gms
DUE TO
(c):

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I attended the deceased from 2/8, 1960, to 2/14, 1960, that I last saw the deceased alive on 2/14, 1960, and that death occurred at 7:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: William C. Morgan M.D. ADDRESS (Street, city or town, state): Salesbury Md DATE SIGNED:

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 2/15/60

22c. NAME OF CEMETERY ~~OR CREMATORY~~: TAYLORVILLE

22d. LOCATION (City, town, or county): BERLIN (RFD) (State): MD

23. FUNERAL DIRECTOR'S SIGNATURE: Anna A. Burbage ADDRESS: Berlin Md

24a. REC'D BY REGISTRAR DATE: FEB 16 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/58

2182172XVO

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2650

CERTIFICATE OF DEATH

Reg. Dist. No. 02645

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ocean City 23X-2
d. STREET ADDRESS: --
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First TERESA Middle READER Last FOTHERGILL

4. DATE OF DEATH: Month FEBRUARY Day 10 Year 19 60

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: FEB 8, 1960
9. AGE (In years last birthday): 2 days
IF UNDER 1 YEAR: Months — Days 2 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): SALISBURY, MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN FOTHERGILL
14. MOTHER'S MAIDEN NAME: MARGARET ELLIOTT

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
INFORMANT Address: MR. JOHN FORTHERGILL OCEAN CITY MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory failure — INTERVAL BETWEEN ONSET AND DEATH
762.5
DUE TO
(b): Cerebral Anoxia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c): atelectasis + Prematurity

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour o. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/8, 1960, to Feb 10, 1960 that I last saw the deceased alive on Feb 10, 1960, and that death occurred at 2 3/4 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: William C Morgan M.D. — ADDRESS (Street, city or town, state): Salisbury, Md — DATE SIGNED: 2/10/60

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 2/12/60
22c. NAME OF CEMETERY OR CREMATORY: TAYLORVILLE
22d. LOCATION (City, town, or county) (State): BERLIN (RFD) MD

23. FUNERAL DIRECTOR'S SIGNATURE: Amon A. Purnell — ADDRESS: Berlin Md

24a. REC'D BY REGISTRAR DATE: FEB 15 '60
24b. REGISTRAR'S SIGNATURE: Clifton S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

2282173XU1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2651

CERTIFICATE OF DEATH

02646

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Pen Gen Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Pittsville
d. STREET ADDRESS: 1 In Village
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print)	First	Middle	Last
	MARY	EDNA	GORDY

4. DATE OF DEATH: Month FEBRUARY Day 12th Year 1960

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White		July 4, 1907	52 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Book-keeper	Book-kepping	Pittsville, Maryland	U S A

13. FATHER'S NAME: George Washington Farlow
14. MOTHER'S MAIDEN NAME: Maggie E. Baker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT (Address)
No			Mr. W. Stansbury Gordy (Husband) Pittsville, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pyelonephritis, chronic — INTERVAL BETWEEN ONSET AND DEATH: unknown
DUE TO
600.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that I attended the deceased from 2/11, 1960, to 2/12 1960, that I last saw the deceased alive on 2/12, 1960, and that death occurred at 4:30A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Wilber R. Ellis Jr. M.D. — ADDRESS (Street, city or town, state): Salisbury, Md. — DATE SIGNED: Feb. 13 1960

PHYSICIAN'S NAME (Type): Dr. Wilber R. Ellis Jr. — Medical Center Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	Feb. 14, 1960	Pittsville Cemetery	Pittsville, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
HOLLOWAY & COMPANY SALISBURY MARYLAND	FEB 17 '60	Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2652

CERTIFICATE OF DEATH

Reg. Dist. No. 02647

1. PLACE OF DEATH
a. COUNTY Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town) Salisbury, Maryland
c. LENGTH OF STAY IN 1b: 26 days
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Talbot
c. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town) St. Michaels, Md. 20x-2
d. STREET ADDRESS: CHESTNUT ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

091

3. NAME OF DECEASED (Type or print): First Nicols — Middle — Last Hardcastle

4. DATE OF DEATH: Month Feb. — Day 7 — Year 19 60

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 11, 1887

9. AGE (In years last birthday) 72 yrs.

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): unk

10b. KIND OF BUSINESS OR INDUSTRY: unk

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Richard Hardcastle

14. MOTHER'S MAIDEN NAME: Henrietta Marie Nicols

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) —

16. SOCIAL SECURITY NO. 215-03-7342

INFORMANT: Hospital Records — Address: Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Right coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 5 min.

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) Arteriosclerotic cardio-vascul. dis. — ?

DUE TO (c) Arteriosclerosis general — ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Rt. hemiplegy due to cerebral thrombosis

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 12, 19 60, to Feb. 7, 19 60, that I last saw the deceased alive on Feb. 7, 19 60, and that death occurred at 6:40A M, from the causes and on the date stated above.

ACTUAL SIGNATURE V. Juerman M.D. — ADDRESS (Street, city or town, state) Salisbury, Maryland — DATE SIGNED 2/7/60

PHYSICIAN'S NAME (Type) V. Juerman, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial — 22b. DATE THEREOF Feb. 10, 1960 — 22c. NAME OF CEMETERY OR CREMATORY Springhill Cemetery — 22d. LOCATION (City, town, or county) (State) Easton, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE S Hamilton Harrison — ADDRESS St. Michaels Md

24a. REC'D BY REGISTRAR DATE FEB 11 '60 — 24b. REGISTRAR'S SIGNATURE Arthur S. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

02648 Reg. Dist. No.

2653

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury
d. STREET ADDRESS: 603 Baker St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ALMA Middle Last Harrington
4. DATE OF DEATH: Month February Day 26 Year 1960

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 28, 1918
9. AGE (In years last birthday): 41 yrs. IF UNDER 1 YEAR: Months 8 Days 28 IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work at Home
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Worcester Co. Md
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Eli W. Smullen
14. MOTHER'S MAIDEN NAME: Lillie Hitch

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
INFORMANT: Mr Geo. W. Harrington (Husband) Address: 603 Baker St Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 32 days
331X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1-24-60, 19__, to 2-26-60, 19__, that I last saw the deceased alive on 2-26-60, 19__, and that death occurred at 5:20 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Wilbur R. Ellis Jr M.D. ADDRESS (Street, city or town, state): Salisbury, Md DATE SIGNED: 2-26-60
PHYSICIAN'S NAME (Type): Dr. Wilber R. Ellis Jr Medical Center Salisbury, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Feb. 29, 1960
22c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park
22d. LOCATION (City, town, or county) (State): Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: HOLLOWAY & COMPANY SALISBURY MARYLAND
24a. REC'D BY REGISTRAR DATE: MAR 2 '60
24b. REGISTRAR'S SIGNATURE: Clifton S. Travis

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02649

2654

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

091

1

2

1

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 936 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Pocomoke 23422
d. STREET ADDRESS: 916 Second Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Myrtle — Middle: May — Last: Hickford

4. DATE OF DEATH: Month: February — Day: 8 — Year: 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 10/13/1874

9. AGE (In years last birthday): 85 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Housework

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Lewis M. Hess

14. MOTHER'S MAIDEN NAME: Emily Elizabeth Albert

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unk. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

INFORMANT: Deer's Head Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary embolism
DUE TO
(b):
DUE TO
(c):

465 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 10 min.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. / p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 17, 1957, to Feb. 8, 1960 that I last saw the deceased alive on Feb. 8, 1960, and that death occurred at 8:15A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: L. V. Maldve M.D. — ADDRESS (Street, city or town, state): Deer's Head State Hospital — DATE SIGNED: 2/8/60

PHYSICIAN'S NAME (Type): L. V. Maldve, M. D. — Salisbury, Maryland

1

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2/10/60

22c. NAME OF CEMETERY OR CREMATORY: Edgehill

22d. LOCATION (City, town, or county) (State): Accomac Va.

23. FUNERAL DIRECTOR'S SIGNATURE: Herbert D. Lewiston — ADDRESS: Accomac, Va.

24a. REC'D BY REGISTRAR DATE: FEB 11 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Timms

VS A1S (4)
1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2673

CERTIFICATE OF DEATH

02650

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Delmar
c. LENGTH OF STAY IN 1b: 14 Yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Maple St.,

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Delmar
d. STREET ADDRESS: Maple
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JAMES — Middle PHILIP — Last HOLLAND

4. DATE OF DEATH: Month 2 — Day 22 — Year 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 17, 1874

9. AGE (In years last birthday): 85 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Own Farm

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Thomas Holland

14. MOTHER'S MAIDEN NAME: Alice Linthicum

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ——

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Mr. Nicholas H. Holland, Salisbury, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: 1 year
DUE TO
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Arteriosclerosis coronary and generalized — 10 years
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1948 to Feb 22, 1960, that I last saw the deceased alive on Feb 18, 1960, and that death occurred at 8:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: L.V. Sohler M.D. — ADDRESS (Street, city or town, state): Delmar, Maryland — DATE SIGNED: 2-24-1960

PHYSICIAN'S NAME (Type): Dr. L.V. Sohler 303 East St., Delmar, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2-25-1960

22c. NAME OF CEMETERY OR CREMATORY: Mt. Olive Cemetery

22d. LOCATION (City, town, or county) (State): Delmar, Delaware

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Hill & Johnson Co. Salisbury, Maryland

24a. REC'D BY REGISTRAR DATE: FEB 26 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2686 **CERTIFICATE OF DEATH** Reg. Dist. No. 02651

1. PLACE OF DEATH
a. COUNTY Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela Springs
c. LENGTH OF STAY IN 1b: 30 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Bridge Street

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Maryland
b. COUNTY Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela Springs, Md,
d. STREET ADDRESS: Bridge Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Walter — Middle Samuel — Last Horsey

4. DATE OF DEATH: Month Feb. — Day 9th — Year 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov. 28, 1894

9. AGE (In years last birthday): 65 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter

10b. KIND OF BUSINESS OR INDUSTRY: Houses

11. BIRTHPLACE (State or foreign country): Delaware

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Washington Robe Horsey

14. MOTHER'S MAIDEN NAME: Kate M. Ellis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): W W I

16. SOCIAL SECURITY NO.: 218-16-5935

17. INFORMANT: Maude Horsey, Address: Mardela Springs, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Heart failure — INTERVAL BETWEEN ONSET AND DEATH
573.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Constipation
DUE TO
(c): Impaction

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour ___ o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/6/60, 19___, to 2/9/60, 19___, that I last saw the deceased alive on 2/7/60, 19___, and that death occurred at 9 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Fred C Quinn M.D.
ADDRESS (Street, city or town, state): Mardela Springs Md
DATE SIGNED: 2/11/60
PHYSICIAN'S NAME (Type): FRED C QUINN

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-12-1960
22c. NAME OF CEMETERY OR CREMATORY: Mardela Memorial
22d. LOCATION (City, town, or county) (State): Mardela Springs, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: W. S. Mandl Co
ADDRESS: Delmar, Del
24a. REC'D BY REGISTRAR DATE: FEB 15 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02652

CERTIFICATE OF DEATH

2655 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 082 Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bishop
d. STREET ADDRESS: RFD 23X-2
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First EDGAR Middle J. Last HUDSON

4. DATE OF DEATH: Month FEBRUARY Day 16 Year 1960

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: Dec. 31, 1893
9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR / IF UNDER 24 HRS. — Months / Days / Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Night Foreman
10b. KIND OF BUSINESS OR INDUSTRY: Dressing Plant
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Curtis Hudson
14. MOTHER'S MAIDEN NAME: Elizabeth Davis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 222-09-1012
INFORMANT: Nelson Hudson Address: Bishop, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrhythmia — INTERVAL BETWEEN ONSET AND DEATH ?? 5 minutes
422.1
DUE TO (b) Arteriosclerotic C.V. Dis — years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chronic pulmonary disease with emphysema
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2-13, 1960, to 2-16, 1960, that I last saw the deceased alive on 2-16-60, 1960, and that death occurred at 11:50 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Joseph C. Fitzgerald M.D. ADDRESS (Street, city or town, state): 707 Camden Avenue Salisbury, Md. DATE SIGNED

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/19/60
22c. NAME OF CEMETERY OR CREMATORY: I O O F
22d. LOCATION (City, town, or county) (State): Bishopville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Peter Whaley ADDRESS: Lillyville, Del.
24a. REC'D BY REGISTRAR DATE: FEB 19 '60
24b. REGISTRAR'S SIGNATURE: Clifton S. Kenna

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 3,5,7 FilmG257 2-24-60 et

2657

CERTIFICATE OF DEATH

02656

Reg. Dist. No.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/58

1. **PLACE OF DEATH** a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 1 Hr.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x Tyaskin
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First ~~First~~ Middle: William — Middle: ANNA — Last: LANE

4. **DATE OF DEATH**: Month: February — Day: 12 — Year: 1960

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 1/1/1871

9. AGE (In years last birthday): 89 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: David Waters

14. MOTHER'S MAIDEN NAME: Dora Stanford

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: —

INFORMANT Address: Mrs Westley Waters, Tyaskin, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebro Vascular accident — INTERVAL BETWEEN ONSET AND DEATH

331X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) — DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour o. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from _____, 19____, to _____, 19___, that I last saw the deceased alive on 2/12/60, 19____, and that death occurred at _____M, from the causes and on the date stated above.

ACTUAL SIGNATURE: A C Mitchell M.D. — ADDRESS (Street, city or town, state): Salisbury, Md. — DATE SIGNED: 2/12/60

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 2/14/60 — 22c. NAME OF CEMETERY OR CREMATORY: Tyaskin Cem. — 22d. LOCATION (City, town, or county) (State): Tyaskin, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: C. W. Mersick — ADDRESS: Bivalve, Md.

24a. REC'D BY REGISTRAR DATE: FEB 15 '60 — 24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2679

02657

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
o. COUNTY: Wicomico — MARYLAND

b. CITY OR TOWN (If outside corporote limits, write RURAL ond give nearest tawn): Delmar

c. LENGTH OF STAY IN 1b: 50 years

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 414 Elizabeth Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico

c. CITY OR TOWN (If outside corporate limits, write RURAL ond give nearest town): Delmar

d. STREET ADDRESS: 414 Elizabeth Street

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Olevia — Middle: Emma — Last: Maddox

4. DATE OF DEATH: Month: Feb. — Day: 2, — Year: 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Feb. 17, 1871

9. AGE (In yeors lost birthdoy): 88 yrs.

IF UNDER 1 YEAR / IF UNDER 24 HRS.: Months | Doys | Hours | Min.

10a. USUAL OCCUPATION (Give kind of wark done during mast af working life, even if retired): At Home

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (Stote or foreign country): Delaware

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles Campbell

14. MOTHER'S MAIDEN NAME: Sarah Tingle

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): ------

16. SOCIAL SECURITY NO.: None

INFORMANT — Address: Mattie Leonard, Salisbury, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Arteriosclerotic heart disease with decompensation — 420.0
DUE TO

Conditions, if ony, which gave rise to immediate couse (a), stating the underlying couse last.
(b) DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): Spondylitis chronic, Anaemia, hypostasis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Hame, farm, factory, street, affice bldg., etc.)

20f. (City or town) (County) (Stote)

21. I certify that I attended the deceased from ____, 1955, to Feb. 2nd, 1960, that I last saw the deceased alive on Feb 1st, 1960, and that death occurred at 11:04 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: L. V. Sohler M.D.

ADDRESS (Street, city or town, state): 303 East Street, Delmar Md.

DATE SIGNED: 2-4-60

PHYSICIAN'S NAME (Type): L. V. Sohler

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2-4-60

22c. NAME OF CEMETERY OR CREMATORY: Melsons

22d. LOCATION (City, town, or county) (State): Delmar, Md.

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: W. S. Mamil Co Delmar, Del

24a. REC'D BY REGISTRAR DATE: FEB 5 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Kimmey

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2687

CERTIFICATE OF DEATH

02653

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 12 years
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: RFD# 2

2. USUAL RESIDENCE (Where deceased lived. If institutian: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town): X Salisbury
d. STREET ADDRESS: RFD # 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John; Middle: C.; Last: Ingram

4. DATE OF DEATH: Month: Feb.; Day: 26; Year: 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: July 29, 1888

9. AGE (In years last birthday): 71 yrs.

IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Reporter

10b. KIND OF BUSINESS OR INDUSTRY: Newspaper

11. BIRTHPLACE (State or foreign country): Indiana

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: M.H. Ingram

14. MOTHER'S MAIDEN NAME: Alice Drake

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): --------

16. SOCIAL SECURITY NO.: 336-01-6216

INFORMANT: Virginia Pattison, Salisbury, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO (b): Cerebral arteriosclerosis — 2 ?
DUE TO (c): —

331X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): —

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Port II of item 18.)

20c. TIME OF INJURY: Hour; a. m. p. m.; Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ____, 19 54, to Feb 26, 19 60, that I last saw the deceased alive on Feb 26, 19 60, and that death occurred at 2:50 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: L.V. Sohler M.D.

ADDRESS (Street, city or town, state): 303 East Street, Delmar Md.

DATE SIGNED: 2-27-60

PHYSICIAN'S NAME (Type): L.V. Sohler

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3-1-1960

22c. NAME OF CEMETERY OR CREMATORY: Winamac

22d. LOCATION (City, town, or county) (State): Winamac, Indiana

23. FUNERAL DIRECTOR'S SIGNATURE: W.S. Morrell Co - Delmar, Md.

ADDRESS:

24a. REC'D BY REGISTRAR: DATE MAR 1 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2656

CERTIFICATE OF DEATH

02654

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Peninsula General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 608 Westover Circle
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Clarence Middle Chester Last Jones

4. DATE OF DEATH: Month February Day 26 Year 1960

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: ~~Da~~Jan. 1, 1891

9. AGE (In years lost birthday): 69 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel Jones

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

INFORMANT: Evelyn Jones Address: Westover Circle

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 442 X — Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 5 days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO: Hypertensive Cardiovascular Renal Disease — Indefinite
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month Doy Yeor 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 22 Feb 1960 to 26 Feb 1960, that I last saw the deceased alive on 26 Feb 1960, and that death occurred at 10:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: E A Purnell, M.D.
ADDRESS (Street, city or town, state): 652 W. Main Salisbury, Md.
DATE SIGNED: 1 March 60
PHYSICIAN'S NAME (Type): E A PURNELL

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3/ 1/1960
22c. NAME OF CEMETERY OR CREMATORY: Green Acres
22d. LOCATION (City, town, or county) (State): Salisbury Md

23. FUNERAL DIRECTOR'S SIGNATURE: Clinton F. Stewart
ADDRESS: Salisbury Md

24a. REC'D BY REGISTRAR DATE: MAR 7 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2688 — 02655 — Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
5M 2/57

1. PLACE OF DEATH
a. COUNTY: Wicomico Co — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EDEN
c. LENGTH OF STAY IN 1b: 1 mos 28 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Route #2

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X EDEN
d. STREET ADDRESS: Route #2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: Elizabeth — Last: King
4. DATE OF DEATH: Month: 2 — Day: 22 — Year: 1960
5. SEX: F M
6. COLOR OR RACE: A A
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12-27-59
9. AGE (In years last birthday): yrs.
IF UNDER 1 YEAR: Months: 1 — Days: 28
IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE
10b. KIND OF BUSINESS OR INDUSTRY: NONE
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Oliver L. King Jr.
14. MOTHER'S MAIDEN NAME: Sarah Francis Wessels

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address: Oliver L. King - Eden, Md - Rt #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: hours
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): 491X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L Royer M.D.
EXAMINER'S NAME (Type): Earl L. Royer
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑
DATE SIGNED: 2-24-60

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-23-60
22c. NAME OF CEMETERY OR CREMATORY: Friendship Cem.
22d. LOCATION (City, town, or county) (State): Allen, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Thornton B. Jolley
ADDRESS: Salisbury, Md
20822 05 X V 2

24a. REC'D BY REGISTRAR — DATE: FEB 29 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2689

CERTIFICATE OF DEATH

Reg. Dist. No. 02658

1. PLACE OF DEATH
a. COUNTY Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Salisbury
c. LENGTH OF STAY IN 1b: 4 weeks
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Rte. # 4

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Connecticut — b. COUNTY New London
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mystic
d. STREET ADDRESS: 38 Dennison Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Walter — Middle John — Last Mallett

4. DATE OF DEATH: Month 2 — Day 7 — Year 19 60

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Feb. 15, 1896

9. AGE (In years last birthday): 63 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ships carpenter

10b. KIND OF BUSINESS OR INDUSTRY: Electric Boat Co.

11. BIRTHPLACE (State or foreign country): Canada

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Mande Mallett

14. MOTHER'S MAIDEN NAME: Henriette Comean

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 041-05-4638

17. INFORMANT: Ethel Adkins, Salisbury, rte. 4 — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Col Phlmonale — INTERVAL BETWEEN ONSET AND DEATH: 1 mo
DUE TO
527.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): emphysema — 10 yrs.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 2, 19 60, to Feb 7, 19 60, that I last saw the deceased alive on Feb 7, 19 60, and that death occurred at 5:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Earl M Beardsley, M.D. — ADDRESS (Street, city or town, state): Salisbury Md — DATE SIGNED: 2/7/60

PHYSICIAN'S NAME (Type): EARL M. BEARDSLEY — Salisbury, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/10/60
22c. NAME OF CEMETERY OR CREMATORY: Stonington Cemetery
22d. LOCATION (City, town, or county) (State): Stonington, Connecticut

23. FUNERAL DIRECTOR'S SIGNATURE: Hill & Johnson Co. — ADDRESS: Salisbury
Franklin B. Hill Jr.

24a. REC'D BY REGISTRAR DATE: FEB 10 '60
24b. REGISTRAR'S SIGNATURE: Clinton S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2658

CERTIFICATE OF DEATH

Reg. Dist. No. 02659

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 11 Yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 419 Washington St.,

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury
d. STREET ADDRESS: 419 Washington St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MILDRED — Middle ANNE — Last MALONE

4. DATE OF DEATH: Month 2 — Day 26 — Year 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug. 13,1926

9. AGE (In years last birthday): 33 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Secretary

10b. KIND OF BUSINESS OR INDUSTRY: Office

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Otis Messick

14. MOTHER'S MAIDEN NAME: Elva Dennis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): **

16. SOCIAL SECURITY NO.: 215-20-4363

17. INFORMANT: W. Fred Malone, Same — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinomatosis Cerebral, neck, + pulmonary — INTERVAL BETWEEN ONSET AND DEATH: 3-4 mos
163X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Adenocarcinoma, rt. lung. — 2+ mos

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 11/20, 1959 to 2/26, 1960, that I last saw the deceased alive on 2/20, 1960, and that death occurred at 3:40 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Rufus Gardner M.D. — ADDRESS (Street, city or town, state): Salisbury, Maryland — DATE SIGNED: 2-26-60

PHYSICIAN'S NAME (Type): Dr. Rufus Gardner, Pine Bluff Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-28-1960
22c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery
22d. LOCATION (City, town, or county) (State): Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Hill & Johnson Co. Salisbury, Maryland

24a. REC'D BY REGISTRAR DATE: FEB 29 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Kiana

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2659

CERTIFICATE OF DEATH

02660

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b: 10 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: PENINSULA GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

23 X 2

082

3. NAME OF DECEASED (Type or print): First: Peter — Middle: P. — Last: MASON

4. DATE OF DEATH: Month: FEBRUARY — Day: 24 — Year: 1960

5. SEX: MALE

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 24-1860

9. AGE (In years last birthday): 99/0/0 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Merchant

10b. KIND OF BUSINESS OR INDUSTRY: Grocery Store

11. BIRTHPLACE (State or foreign country): Stockton, Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Peter Mason

14. MOTHER'S MAIDEN NAME: Annie Corbin

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or Unknown) (If yes, give war or dates of service): No ~~WW-03-1616~~

16. SOCIAL SECURITY NO.: 219-03-7668

INFORMANT: Mr Phillip C. Mason — Address: 237 W. Garnet St Phila, 32 Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute adrenal insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 48 hr.

610 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Prostatic surgery — 72 hr.
DUE TO (c): Benign prostatic hypertrophy — 10 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Generalized arteriosclerosis, hypertension

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb 14, 1960, to Feb 24, 1960, that I last saw the deceased alive on Feb 24, 1960, and that death occurred at 1:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Raymond M. Your M.D. — ADDRESS (Street, city or town, state): 707 Camden Ave. Salisbury Md — DATE SIGNED:

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Feb 27/60

22c. NAME OF CEMETERY OR CREMATORY: Methodist Cemetery

22d. LOCATION (City, town, or county) (State): Stockton Md

23. FUNERAL DIRECTOR'S SIGNATURE: Lilley E. Dennis — ADDRESS: Snow Hill, Md

24a. REC'D BY REGISTRAR DATE: FEB 26 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02661

2660

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: WICOMICO — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b: 36 HOURS
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: PENINSULA General HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WORCESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): POCOMOKE CITY 2342-2
d. STREET ADDRESS: 708 CEDAR STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ROY Middle WILLIAM Last MASON

4. DATE OF DEATH: Month February Day 1 Year 1960

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JUNE 4, 1902

9. AGE (In years last birthday): 57 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): TRUCK DRIVER

10b. KIND OF BUSINESS OR INDUSTRY: LUMBER

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN WILLIAM MASON

14. MOTHER'S MAIDEN NAME: WEALTHY MERRITT

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 213-01-9107

INFORMANT: MRS HAROLD LAMBERTSON, Address: POCOMOKE CITY, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 day
331X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 31, 1960 to Feb 1, 1960, that I last saw the deceased alive on Feb 1, 1960, and that death occurred at 4:35 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Willus R. Ellis M.D.
ADDRESS (Street, city or town, state): Salisbury, Md.
DATE SIGNED: 2-1-60

PHYSICIAN'S NAME (Type): WILBUR R. ELLIS, JR.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 2-4-60
22c. NAME OF CEMETERY OR CREMATORY: GOODWILL METHODIST
22d. LOCATION (City, town, or county) (State): RURAL POCOMOKE CITY, MD.

23. FUNERAL DIRECTOR'S SIGNATURE: Henry S. Watson
ADDRESS: POCOMOKE CITY, MD.

24a. REC'D BY REGISTRAR DATE: FEB 8 '60
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/5B

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2699 **CERTIFICATE OF DEATH** Reg. Dist. No. 02662

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mardela
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Maple shade nursing home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury
d. STREET ADDRESS: 329 Camden Ave.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First OSWIN Middle WILLIAM Last MENK, Sr.

4. DATE OF DEATH: Month 2 Day 23 Year 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 2-16-1877

9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Statistician

10b. KIND OF BUSINESS OR INDUSTRY: Gov.

11. BIRTHPLACE (State or foreign country): Illinois

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Menk

14. MOTHER'S MAIDEN NAME: Eliza Fischer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): ----

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Dr. Oswin W. Menk Jr. Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 8 hours
DUE TO
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan, 1960, to Feb 2, 1960, that I last saw the deceased alive on Feb 2, 1960, and that death occurred at 9:35A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: H S Kuhlman M.D. ADDRESS (Street, city or town, state): Sharptown, Mardela, Maryland DATE SIGNED: 2-24-1960

PHYSICIAN'S NAME (Type): Dr. H.S. Kuhlman Sharptown, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: 2-26-1960
22c. NAME OF CEMETERY OR CREMATORY: J.William Lee's Crematory
22d. LOCATION (City, town, or county) (State): Washington, D.C.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Hill & Johnson Co. Salisbury, Maryland

24a. REC'D BY REGISTRAR DATE: FEB 26 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

Burge C. Hill II

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2661

CERTIFICATE OF DEATH

02663

Reg. Dist. No.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

1. PLACE OF DEATH a. COUNTY: Wicomico — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland — b. COUNTY: Queen Anne's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury c. LENGTH OF STAY IN 1b: 450 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sudlersville 17X-2
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Deer's Head State Hospital	d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Elsie	Catherine	Minner	Feb.	19	19 60

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White		2/16/1894	66 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Housework	Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Ennis	Mollie Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	INFORMANT: Deer's Head Hospital — Address: Records
Unk.		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Passive congestion of lungs	24 hrs
DUE TO (b)	Arteriosclerotic cardiovascular disease	?
DUE TO (c)		

422.1

Conditions, if ony, which gove rise to immediate couse (a), stoting the underlying couse lost.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Hydronephrosis

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factary, street, affice bldg., etc.)	20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from Nov. 26, 1958, to Feb. 19, 1960, that I last saw the deceased alive an Feb. 18, 1960, and that death accurred at 2 A. M, fram the causes and an the date stated abave.

ACTUAL SIGNATURE: L. V. Maldve M.D. — ADDRESS (Street, city or town, state): Deer's Head State Hospital — DATE SIGNED: 2/19/60

PHYSICIAN'S NAME (Type): L. V. Maldve, M. D. — Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	Feb. 21, 1960	Sudlersville Cemetery	Sudlersville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Edward F. Travers Millington Md	FEB 24 '60	Arthur E. Travers

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2691 **CERTIFICATE OF DEATH** 02664

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sharptown
c. LENGTH OF STAY IN 1b: 22 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Park Avenue

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Sharptown
d. STREET ADDRESS: Park Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First MARTHA Middle ELIZABETH Last MORGAN

4. DATE OF DEATH: Month Feb. Day 15, Year 1960

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Sept. 3. 1870
9. AGE (In years last birthday): 89 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: William H. Davis
14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address: Mr. Joe Morgan Park Ave. Sharptown Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteria Sclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: 3 mos
420.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec 59, to Feb 15 1960, that I last saw the deceased alive on Feb 15 1960, and that death occurred at 10:?1 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: J Rascoe Elliott M.D. — ADDRESS (Street, city or town, state): Laurel — Del — DATE SIGNED:
PHYSICIAN'S NAME (Type): J. Rascoe Elliott

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Feb 18 1960
22c. NAME OF CEMETERY OR CREMATORY: Riverton Cemetery
22d. LOCATION (City, town, or county) (State): Riverton Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Smith Funeral Home Sharptown, Md.
24a. REC'D BY REGISTRAR DATE: FEB 19 '60
24b. REGISTRAR'S SIGNATURE: Esther S. Hearn

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2692

CERTIFICATE OF DEATH

02665

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Hill Sanitarium

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md.
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3 Y 0 1-4
d. STREET ADDRESS 1521 Kingsway Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
BERTHA	MAE	NORTH	Feb.	7,	19 60

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	white		Aug. 5, 1880	79 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	--	Md.	

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William Jenkins	Sarah Elizabeth Topping

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
no	no	Mrs. Elizabeth M. Wilson - Delmar, Del.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-vascular Renal Disease — INTERVAL BETWEEN ONSET AND DEATH

442 x

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ____, 1958, to 2-7, 1960, that I last saw the deceased alive on 2-4, 1960, and that death occurred at 9:30 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE Philip A Insley M.D. ADDRESS (Street, city or town, state) Salisbury Md DATE SIGNED 2-7-60

PHYSICIAN'S NAME (Type) Philip A. Insley

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	2/10/60	Loudon Park Cem.	Balto., Md.

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Wm. J. Sickener & Sons - Balto 17 Md		FEB 9 '60	Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2662

02666

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1. **PLACE OF DEATH** a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: Life Time
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Princess Anne
d. STREET ADDRESS: 19X-2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Wallace — Middle: Preston — Last: Nutter

4. **DATE OF DEATH**: Month: February — Day: 21 — Year: 1960

5. SEX: Male

6. COLOR OR RACE: NEGRO

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: II/4/1904

9. AGE (In years last birthday): 55 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Self Employed

10b. KIND OF BUSINESS OR INDUSTRY: Raising Chicken

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U S A.

13. FATHER'S NAME: William Nutter

14. MOTHER'S MAIDEN NAME: Emma King

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

INFORMANT: Jane Nutter — Address: Princess Anne, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute bronchitis — INTERVAL BETWEEN ONSET AND DEATH: 2 Days

DUE TO (b): Pulmonary emphysema — INTERVAL BETWEEN ONSET AND DEATH: unknown

DUE TO (c):

502.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. / p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I attended the deceased from 2-18, 1960, to 2-21, 1960, that I last saw the deceased alive on 2-21, 1960, and that death occurred at 12 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: William R. Ellis M.D. — ADDRESS (Street, city or town, state): Salisbury, Md. — DATE SIGNED: 2-21-60

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 2/25/60

22c. NAME OF CEMETERY OR CREMATORY: John Wesley

22d. LOCATION (City, town, or county) (State): Princess Anne, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: William H. James Jr. Princess Anne, Maryland

24a. REC'D BY REGISTRAR DATE: FEB 26 '60

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2693

CERTIFICATE OF DEATH

Reg. Dist. No. 02667

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Powellville
c. LENGTH OF STAY IN 1b: 30Yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): × Powellville
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First WILLARD Middle H. Last PALMER
4. DATE OF DEATH: Month Feb 14, Day 1960, Year 19

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: Nov. 11, 1878
9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Own farm
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William H. Palmer
14. MOTHER'S MAIDEN NAME: Hettie Ann Littleton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): XX (If yes, give war or dates of service): XX
16. SOCIAL SECURITY NO.: XX
17. INFORMANT — Address: Mrs. Mary Palmer Powellville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Chronic Deg. Myocarditis & Anasarka — INTERVAL BETWEEN ONSET AND DEATH: 3 mo
420.0
DUE TO (b): Arteriosclerotic Heart Disease — 12 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. / p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan, 1947, to Feb 14, 1960, that I last saw the deceased alive on Feb 14, 1960, and that death occurred at 8:45 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Leonard Tadder M.D. ADDRESS (Street, city or town, state): Berlin, Md. DATE SIGNED: 2/16/60

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2/16/60
22c. NAME OF CEMETERY OR CREMATORY: St. Johns
22d. LOCATION (City, town, or county) (State): Powellville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Peter Whaley Jr. ADDRESS: Pittsville, Md.
24a. REC'D BY REGISTRAR DATE: FEB 16 '60
24b. REGISTRAR'S SIGNATURE: Darling L. Fooks

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02668

2663

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporote limits, write RURAL ond give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 411 Washington St

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporote limits, write RURAL ond give nearest town): 12 Salisbury
d. STREET ADDRESS: 411 Washington St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN — Middle EDWARD — Last PARKER

4. DATE OF DEATH: Month FEB. — Day 3rd — Year 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 22,1880

9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Employee of Pa. Railroad-Watchman

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Wicomico Co. Maryland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Stansbury Parker

14. MOTHER'S MAIDEN NAME: Amanda Phipps

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unk
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

INFORMANT: Mrs. Cleora Parker (Wife) Address: 411 Washington St Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Myocardial Infarction
DUE TO (b): Coronary Arteriosclerosis.
DUE TO (c):

Conditions, if ony, which gove rise to immediote couse (o), stoting the under-lying couse lost.

420.1

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Doy, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from February 1, 1959 to Feb 3, 1960 that I last saw the deceased alive on Feb 1, 1959, and that death occurred at 4:30P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Thomas C. Hill. Jr. M.D.
ADDRESS (Street, city or town, state): Pine Bluff Rd. Salisbury, Maryland
DATE SIGNED: Feb. 5 /1960

PHYSICIAN'S NAME (Type): Dr. Rufus S. Gardner / Dr. Thomas C. Hill

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Feb. 6, 1960
22c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery
22d. LOCATION (City, town, or county) (State): Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: HOLLOWAY & COMPANY SALISBURY MARYLAND

24a. REC'D BY REGISTRAR DATE: FEB 8 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2664 02669

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: WICOMICO — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b: 78 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: PENINSULA GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: DELAWARE — b. COUNTY: SUSSEX
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): DELMAR — 46X-3
d. STREET ADDRESS: R 7 D # 2
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First HARRY — Middle LINWOOD — Last PHILLIPS

4. DATE OF DEATH: Month FEBRUARY — Day 22 — Year 1960

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 10-4-1881
9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER
10b. KIND OF BUSINESS OR INDUSTRY: FARM
11. BIRTHPLACE (State or foreign country): DELMAR - DEL
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: J. DAVIS PHILLIPS
14. MOTHER'S MAIDEN NAME: ALLIE F HEARN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 222-07-1329
INFORMANT Address: OLA PHILLIPS - DELMAR DEL

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Chronic Gomerulo nephritis — INTERVAL BETWEEN ONSET AND DEATH: unknown
DUE TO
592X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2-20, 1960 to 2-22 1960 that I last saw the deceased alive on 2-22, 1960, and that death occurred at 4:35 PM, from the causes and on the date stated above.

ACTUAL SIGNATURE: William R. Ellis Jr. M.D. — ADDRESS (Street, city or town, state): Salisbury, Md. — DATE SIGNED: 2-22-60

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 2-24-60
22c. NAME OF CEMETERY OR CREMATORY: RALPH HILL
22d. LOCATION (City, town, or county) (State): DELMAR - DEL

23. FUNERAL DIRECTOR'S SIGNATURE: W-S-Mard Co - Delmar, Del — ADDRESS
24a. REC'D BY REGISTRAR DATE: FEB 25 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Rivers

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2665

CERTIFICATE OF DEATH

Reg. Dist. No. 02670

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 4 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill 23 x 2
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: James — Middle: Alfred — Last: Purnell

4. DATE OF DEATH: Month: February — Day: 10 — Year: 1960

5. SEX: Male

6. COLOR OR RACE: Col

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Dec. 12 1891

9. AGE (In years last birthday): 68 yrs. 2 mos.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sailor

10b. KIND OF BUSINESS OR INDUSTRY: Lumber Mill

11. BIRTHPLACE (State or foreign country): Snow Hill, Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George Purnell

14. MOTHER'S MAIDEN NAME: Martha E. Taylor

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

INFORMANT: Mrs Mildred Shockley — Address: Parsonsburg, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Atelectasis Right Lung Bx/52 — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): Bronchopneumonia and
DUE TO (c): Paralytic ileus

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

491X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from February 7, 1960, to Feb. 10, 1960, that I last saw the deceased alive on Feb 10, 1960, and that death occurred at 10 15 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Thomas C. Hall Jr. M.D. — ADDRESS (Street, city or town, state): Pine Bluff Road Salisbury, Md — DATE SIGNED: 2/10/60

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: Feb 14 60 — 22c. NAME OF CEMETERY OR CREMATORY: Little Leaping Cemetery — 22d. LOCATION (City, town, or county) (State): Snow Hill, Md

23. FUNERAL DIRECTOR'S SIGNATURE: Wm E Dennis — ADDRESS: Snow Hill, Md

24a. REC'D BY REGISTRAR DATE: FEB 15 '60 — 24b. REGISTRAR'S SIGNATURE: Anthony S Krause

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/58

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2666 Item 9 FilmG256 2-23-60 et

CERTIFICATE OF DEATH

Reg. Dist. No. 02671

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury md
c. LENGTH OF STAY IN 1b: 15 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury md
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Ola Middle Pennell Last
4. DATE OF DEATH: Month 2- Day 9 Year 1960
5. SEX: female
6. COLOR OR RACE: Col
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Approx. 74 yrs.
9. AGE (In years last birthday)
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): md.
12. CITIZEN OF WHAT COUNTRY? USA.
13. FATHER'S NAME: Levin Pennell
14. MOTHER'S MAIDEN NAME:
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or Unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 214-32-2047
INFORMANT: Res Levin Pennell Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Heart FAILURE — INTERVAL BETWEEN ONSET AND DEATH: 5 min
443X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Chronic Heart FAILURE — 2 months
DUE TO (c): Hypertensive cardiovascular desease — 10 yr

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Generalized arteriosclerosis, Diabetes millitus
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factary, street, affice bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I ottended the deceased from July 22, 1959, to Febrwa 9, 1960 that I lost sow the deceosed olive on January 27, 1960, ond that deoth occurred ot 8:50 M, from the couses ond on the dote stoted abave.

ACTUAL SIGNATURE: Robert T Adkins M.D. ADDRESS (Street, city or town, state): Fruitland DATE SIGNED: 2/11/60
PHYSICIAN'S NAME (Type): Robert T. ADKINS FRUITLAND

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-12-60
22c. NAME OF CEMETERY OR CREMATORY: Green Acers Cem
22d. LOCATION (City, town, or county) (State): Salisbury Md
23. FUNERAL DIRECTOR'S SIGNATURE: Parker McCuch ADDRESS
24a. REC'D BY REGISTRAR DATE FEB 17 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2667 **CERTIFICATE OF DEATH** 02672

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 6 Mons.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Spring Hill Pr. Sana.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury
d. STREET ADDRESS: N. Division St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
SARAH	ANNA	REIHL	2	13	1960

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White		Jan 1,1871	89 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House Wife	Own Home	Pa.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Henry Topley	Elizabeth Winfield

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
no		Mrs. Ralph O. Dulaney, Fruitland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 6 hrs
DUE TO
(b): Arteriosclerosis
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ____, 19__, to 2/13, 19__, that I last saw the deceased alive on 2/13/60, 19__, and that death occurred at 7 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Fred R. Gramse M.D. — ADDRESS (Street, city or town, state): Salisbury, Maryland — DATE SIGNED: 2-15-1960

PHYSICIAN'S NAME (Type): Dr. Fred R. Gramse S. Division St., Salisbury, Maryland.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	2-17-1960	Ivy Hill Cemetery	Mt Airy * Phila. Pa.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
Hill & Johnson Co. Salisbury, Maryland	FEB 17 '60	Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2668

CERTIFICATE OF DEATH

02673 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Wicomico MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stockton 23X-2
d. STREET ADDRESS P.O. Box 83
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Cora Middle Smith Last Selby
4. DATE OF DEATH Month February Day 15 Year 1960
5. SEX Female
6. COLOR OR RACE Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH MARCH 3, 1882
9. AGE (In years lost birthday) 77 yrs.
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER
10b. KIND OF BUSINESS OR INDUSTRY Factory-Work
11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Daniel Smith
14. MOTHER'S MAIDEN NAME Mahalie Duncain
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 219-07-3740
INFORMANT Address Bessie Marshall - Stockton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage. — INTERVAL BETWEEN ONSET AND DEATH 2 hours.
331X
Conditions, if ony, which gove rise to immediate couse (a), stoting the underlying couse lost.
DUE TO (b) Cerebral Thrombosis Middle Cerebral Artery — 3 days
DUE TO (c) Arteriosclerotic Cerebral Vase. Dis — =

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
Diabetes Mellitus
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Doy, Year 19
20d. INJURY OCCURRED While ot work ☐ Not while ot work ☐
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 13 February 1960 to 15 February, 1960, that I lost sow the deceased olive on 15 February, 1960, and that death occurred at 6:45 M, from the causes and on the date stated above.

ACTUAL SIGNATURE Joseph C. Fitzgerald M.D. M.D. — ADDRESS (Street, city or town, state) 707 Camden Avenue Salisbury Md. — DATE SIGNED

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 2-21-60
22c. NAME OF CEMETERY OR CREMATORY Home Beneficial
22d. LOCATION (City, town, or county) (State) Stockton, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Edgar Wheaton - New Church, Va.
24a. REC'D BY REGISTRAR DATE FEB 19 '60
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02674

2669

CERTIFICATE OF DEATH

Reg. Dist. No.

1. **PLACE OF DEATH**
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General Hospital

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Deal Island 19X-2
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First BESSIE Middle MAY Last Shores

4. **DATE OF DEATH**: Month February Day 26 Year 1960

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: MAY 13 - 1874
9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR / IF UNDER 24 HRS. — Months / Days / Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Household
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: JAMES SOMERS
14. MOTHER'S MAIDEN NAME: JULIA WHITE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: NONE
INFORMANT: Edwin Shores — Address: Deal Island Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarct, acute — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that I attended the deceased from 2-25, 1960, to 2-26, 1960, that I last saw the deceased alive on 2-26-60, 1960, and that death occurred at 5:00 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Walter A. Ellis Jr. M.D.
ADDRESS (Street, city or town, state): Salisbury, Md
DATE SIGNED: 2-26-60
PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-28-60
22c. NAME OF CEMETERY OR CREMATORY: St. Johns Methodist
22d. LOCATION (City, town, or county) (State): Deal Island Md

23. FUNERAL DIRECTOR'S SIGNATURE: E. Shockley
ADDRESS: Deal Island Md

24a. REC'D BY REGISTRAR DATE: MAR 2 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2694

02675

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Miami Motel -Route#13 (North)

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Salisbury
d. STREET ADDRESS: 1 R.D.# 5
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First KATHRYN Middle JOYCE Last SILVA

4. DATE OF DEATH: Month FEBRUARY Day 13th Year 1960

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan.18,1937

9. AGE (In years last birthday): 23 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Employee at Hospital

10b. KIND OF BUSINESS OR INDUSTRY: (Tech. In Lab)

11. BIRTHPLACE (State or foreign country): Salisbury, Maryland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Newell L.Kelly

14. MOTHER'S MAIDEN NAME: Kathryn LeCompte

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mr. John F. Kerr (Step-Father) Address: R.D.# 5 Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Asphyxia
983X
DUE TO (b): Strangulation
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: Sudden

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Husband Strangulated her during quarrel

20c. TIME OF INJURY: Hour 12 a.m. p.m. Month, Day, Year: 2 14 1960

20d. INJURY OCCURRED: While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Miami Motel

20f. (City or town) Salisbury (County) Wicomico (State) Md

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined cause ☐.

ACTUAL SIGNATURE: Earl L Royer M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): Dr. Earl L. Royer

DATE SIGNED: Feb. 16 /1960

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Feb.17,1960

22c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery

22d. LOCATION (City, town, or county) (State): Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: HOLLOWAY & COMPANY SALISBURY MARYLAND

24a. REC'D BY REGISTRAR DATE: FEB 17 '60

24b. REGISTRAR'S SIGNATURE:

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2670 **CERTIFICATE OF DEATH**

02676

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 144 Delaware Street

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 12 Salisbury
d. STREET ADDRESS: 144 Delaware Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Edna — Middle: V. — Last: Stewart

4. DATE OF DEATH: Month: Febuary — Day: 28 — Year: 19 60

5. SEX: Female

6. COLOR OR RACE: Col.

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 9,

9. AGE (In years last birthday): 66 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Ceaser Barckley

14. MOTHER'S MAIDEN NAME: Sharlet Noble

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 166-09-8219

17. INFORMANT: Harry Stewart — Address: 144 Delaware St

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 022 x — DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): — DUE TO
(c): Aortic Aneurysm

INTERVAL BETWEEN ONSET AND DEATH: 1 yr.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. / p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 28 Feb 19 59 to 28 Feb 19 60, that I last saw the deceased alive on 28 Feb 19 60, and that death occurred at 3:00 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: E A Parker M.D. — ADDRESS (Street, city or town, state): 624 W Main St Salisbury, Md. — DATE SIGNED: 2 Mar 60

PHYSICIAN'S NAME (Type): E A PARKER

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 3/ 3/1960

22c. NAME OF CEMETERY OR CREMATORY: Green Acres

22d. LOCATION (City, town, or county) (State): Salisbury Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Clinton F. Stewart — ADDRESS: Salisbury Md

24a. REC'D BY REGISTRAR — DATE: MAR 7 '60

24b. REGISTRAR'S SIGNATURE: Arthur L. Kenna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57

1.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2671

CERTIFICATE OF DEATH

02677

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b: 1 Day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: PENINSULA GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Md
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill 23X-2
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

082

3. NAME OF DECEASED (Type or print): First Ralph — Middle W. — Last Truitt

4. DATE OF DEATH: Month FEBRUARY — Day 5 — Year 1960

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 13 1886

9. AGE (In years last birthday): 73 YRS.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Own Farm

11. BIRTHPLACE (State or foreign country): Snow Hill Md

12. CITIZEN OF WHAT COUNTRY?

I

13. FATHER'S NAME: Jesse Truitt

14. MOTHER'S MAIDEN NAME: Margaret Bruner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 213-10-7666

INFORMANT: Mrs Lola V. Truitt Address: Snow Hill Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Shock — INTERVAL BETWEEN ONSET AND DEATH: 6 hours
DUE TO
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Myocardial Infarction — ? 14 hrs.
DUE TO
(c): Coronary artery disease — ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): none

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

0

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from 10 30 AM 5 Feb 19 60, to 5 Feb, 1960, that I last saw the deceased alive on 5 Feb, 1960, and that death occurred at 12 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Joseph C. Fitzgerald M.D. M.D. — ADDRESS (Street, city or town, state): 707 Camden Avenue Salisbury — DATE SIGNED:

PHYSICIAN'S NAME (Type)

1

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: Feb 1960 — 22c. NAME OF CEMETERY OR CREMATORY: Bates Methodist — 22d. LOCATION (City, town, or county) (State): Snow Hill Md

23. FUNERAL DIRECTOR'S SIGNATURE: Elley E. Timms — ADDRESS: Snow Hill Md

24a. REC'D BY REGISTRAR DATE: FEB 8 '60 — 24b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2672 **CERTIFICATE OF DEATH** 02678

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 282 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge 0913.2
d. STREET ADDRESS: Linden Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

091

3. NAME OF DECEASED (Type or print): First: Holmes — Middle: E. — Last: Venable

4. DATE OF DEATH: Month: 2 — Day: 26 — Year: 1960

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 11/8/79

9. AGE (In years last birthday): 80 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Caretaker

10b. KIND OF BUSINESS OR INDUSTRY: CARETAKER

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George W. Venable

14. MOTHER'S MAIDEN NAME: Mary Francis Stokes

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): unknown (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

INFORMANT: Deer's Head Records Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Thrombosis of Coronary Artery — INTERVAL BETWEEN ONSET AND DEATH: 1 Hour

420.0

DUE TO (b): Arteriosclerotic Heart Disease — Years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Macrocytic Anemia

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 5/20, 1959, to 2/26, 1960, that I last saw the deceased alive on 2/26 1960, and that death occurred at 6:05 a.m., from the causes and on the date stated above.

ACTUAL SIGNATURE: Lee L Lawry M.D. — ADDRESS (Street, city or town, state): Deer's Head State Hospital — DATE SIGNED: 2/26/60

PHYSICIAN'S NAME (Type): Lee L. Lawry, M.D. — Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 2/29/60

22c. NAME OF CEMETERY OR CREMATORY: EAST NEW MARKET

22d. LOCATION (City, town, or county) (State): EAST NEW MARKET, MD.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: LECOMPTE FUNERAL SERVICE, CAMBRIDGE MD.

24a. REC'D BY REGISTRAR DATE: MAR 8 '60

24b. REGISTRAR'S SIGNATURE: Arthur S Krewer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2673 02679

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY WICOMICO MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY
c. LENGTH OF STAY IN 1b D.O.A
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) PENINSULA GENERAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE DELAWARE b. COUNTY SUSSEX
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SEAFORD - RURAL - GALESTOWN, MD
d. STREET ADDRESS RFD # 3 46x3
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First CURTIS Middle GLENN Last VICKERS
4. DATE OF DEATH Month 2 Day 10 Year 1960

5. SEX M
6. COLOR OR RACE W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH DEC 28, 1956
9. AGE (In years last birthday) 3 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE
10b. KIND OF BUSINESS OR INDUSTRY NONE
11. BIRTHPLACE (State or foreign country) GALESTOWN, MD
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME JOHN EDWARD VICKERS
14. MOTHER'S MAIDEN NAME EUDINE M. MONTGOMERY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) NO
16. SOCIAL SECURITY NO. NO
17. INFORMANT Address JOHN EDWARD VICKERS - SEAFORD, DEL, RFD #3

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) FRACTURED SKULL — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN
812X
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) CHILD RAN OUT IN FRONT OF CAR,
20c. TIME OF INJURY Hour 4:45 a.m. p.m. Month, Day, Year 2-10-1960
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HIGHWAY
20f. (City or town) GALESTOWN, (County) Dorch, (State) MD

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE Earl L Royer M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 2-12-60
EXAMINER'S NAME (Type) EARL L ROYER, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
22b. DATE THEREOF FEB 13, 1960
22c. NAME OF CEMETERY OR CREMATORY GALESTOWN
22d. LOCATION (City, town, or county) GALESTOWN, MD (State)

23. FUNERAL DIRECTOR'S SIGNATURE Paul J. Smith ADDRESS Sharptown, md
24a. REC'D BY REGISTRAR DATE FEB 16 '60
24b. REGISTRAR'S SIGNATURE Arthur S. Krauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 02680

1. PLACE OF DEATH
a. COUNTY: Wicomico — 2674 — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: PENINSULA GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge — 0913.2
d. STREET ADDRESS: 129 Pine Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First NOBLE Middle H. Last WEBB

4. DATE OF DEATH: Month FEBRUARY Day 3 Year 1960

5. SEX: MALE
6. COLOR OR RACE: NEGRO
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan 10 1896
9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmland
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Caroline Co, Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James R Webb
14. MOTHER'S MAIDEN NAME: Martha Kimmey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
INFORMANT: Addie Hughes, Address: Cambridge Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Small bowel Volvulus & Infarction — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs.
DUE TO
570.3
Conditions, if ony, which gove rise to immediote couse (a), stoting the underlying cause lost.
(b): Peritonitis
DUE TO
(c): Bronchopneumonia — 2 months
Parkinsonism - Senu

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Dehydration, Malnutrition,
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from FEBRUARY 3, 1960, to FEBRUARY 3 1960 that I last saw the deceased alive on FEBRUARY 3, 1960, and that death occurred at 5:02 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: William B Long M.D. ADDRESS (Street, city or town, state): Med Center Salisbury, md DATE SIGNED: 2/4/60

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Feb 7 1960
22c. NAME OF CEMETERY OR CREMATORY: Mt Pleasant
22d. LOCATION (City, town, or county) (State): Preston, Md

23. FUNERAL DIRECTOR'S SIGNATURE: Herbert M McLane Jr. ADDRESS: Camb, Md
24a. REC'D BY REGISTRAR DATE: FEB 15 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2675 **CERTIFICATE OF DEATH** Reg. Dist. No. 02681

1. **PLACE OF DEATH**
a. COUNTY: WICOMICO — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: PENINSULA GENERAL HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: WICOMICO
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): *SALISBURY
d. STREET ADDRESS: ROUTE #1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: LOUIS — Middle: S. — Last: WILLIAMS

4. **DATE OF DEATH**: Month: FEBRUARY — Day: 3 — Year: 1960

5. SEX: MALE

6. COLOR OR RACE: NEGRO

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4-16-86

9. AGE (In years last birthday): 73 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER

10b. KIND OF BUSINESS OR INDUSTRY: RAILROAD

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: SAMUEL WILLIAMS

14. MOTHER'S MAIDEN NAME: MARIA WILSON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.: ?

INFORMANT — Address: MRS. EDITH WILLIAMS, SALISBURY MD, RT #1

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): BRONCHOPNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b): OLD RHEUMATIC FEVER & GENERALIZED
DUE TO (c): ARTERIOSCLEROSIS

450.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from 1957, 19____, to 2/3/60, 19____, that I last saw the deceased alive on 2/3/60, 19____, and that death occurred at 11 A. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: A.C. Smith M.D. — ADDRESS (Street, city or town, state): Salisbury Md — DATE SIGNED: 2/5/60

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — 22b. DATE THEREOF: 2-7-60 — 22c. NAME OF CEMETERY OR CREMATORY: GREEN ACRE CEM. — 22d. LOCATION (City, town, or county) (State): SALISBURY MD.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: THORNTON B. JOLLEY, SALISBURY, MD.

24a. REC'D BY REGISTRAR DATE FEB 9 '60 — 24b. REGISTRAR'S SIGNATURE: Arthur S. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2695

CERTIFICATE OF DEATH

02682

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): (Rural) Parsonsburg

c. LENGTH OF STAY IN 1b:

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: R.D.# 1

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Parsonsburg (Rural)

d. STREET ADDRESS: R.D.# 1

e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
WILLIAM	FRANKLIN	WIMBROW	FEBRUARY	23	1960

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years lost birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White	MARRIED [X]	October 17, 1889	70 yrs.	4	6		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Farmer	Farming	Pittsville, Maryland	U S A

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Sampson A. Wimbrow	Sarah Collins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
Unk			Mrs. Anna M. Wimbrow (Wife) R.D.# 1 Parsonsburg, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 hr.

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) Generalized arteriosclerosis — 5 yrs.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Cerebral Thrombosis

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work [ ] Not while at work [ ]	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that I attended the deceased from Jan, 1954 to Feb 23, 1960, that I last saw the deceased alive on Feb 23, 1960, and that death occurred at 2:45 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Earl M. Beardsley M.D. — ADDRESS (Street, city or town, state): Maryland Ave. Salisbury, Maryland — DATE SIGNED: Feb. 24, 1960

PHYSICIAN'S NAME (Type) Dr. Earl M. Beardsley

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	Feb. 26, 1960	Parsonsburg Cemetery	Parsonsburg, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
HOLLOWAY & COMPANY	SALISBURY MARYLAND	FEB 26 '60	Carlton L. Travers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2676 CERTIFICATE OF DEATH

Reg. Dist. No. 02683

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Peninsula General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Stockton 23x-2
d. STREET ADDRESS: Bx. 116
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First George Middle Edward Last Wise

4. DATE OF DEATH: Month February Day 26 Year 1960

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 9, 1904

9. AGE (In years last birthday): 55 yrs.

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Mill Work

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Wise

14. MOTHER'S MAIDEN NAME: Henrietta Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 220-16-9799

INFORMANT: Eugene Wise Address: Bishopville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Subarachnoid Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 9 days
DUE TO
330x
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 2/17, 1960 to 2/26, 1960, that I last saw the deceased alive on 2/26, 1960, and that death occurred at 11:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Paul J. Gilmore M.D. ADDRESS (Street, city or town, state): Salisbury Md. DATE SIGNED: 2/26/60

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 3-5-60
22c. NAME OF CEMETERY OR CREMATORY: Mt. Hope
22d. LOCATION (City, town, or county) (State): Pocomoke, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Edgar Wharton New Church, Va.

24a. REC'D BY REGISTRAR DATE MAR 3 '60

24b. REGISTRAR'S SIGNATURE: Curtis S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/SB

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2677 CERTIFICATE OF DEATH

02684 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 19 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Caroline (Resident
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Centreville (Queen Anne's Co.)
d. STREET ADDRESS: 419 S. Commerce Street 05x.2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Florence; Middle; Last Wyatt
4. DATE OF DEATH: Month February; Day 15; Year 1960
5. SEX: Female
6. COLOR OR RACE: Colored
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 3/7/1876
9. AGE (In years last birthday): 83 yrs. IF UNDER 1 YEAR: Months; Days; IF UNDER 24 HRS.: Hours; Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10b. KIND OF BUSINESS OR INDUSTRY: Housework
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Charles Wright
14. MOTHER'S MAIDEN NAME: Mary Downes
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Unk. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
INFORMANT: Deer's Head Hospital Address: Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypostatic Congestion of lungs — INTERVAL BETWEEN ONSET AND DEATH: 5 days
DUE TO (b): arteriosclerotic C-V-D, decompensated — 3 weeks
DUE TO (c): arterio sclerosis, gen — ?
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last. 422.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from January 27, 1960, to February 15 1960 that I last saw the deceased alive on Feb. 15, 1960, and that death occurred at 10:05 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: R J Gore MD — M.D. — ADDRESS (Street, city or town, state): Deer's Head Hospital — DATE SIGNED: 2-17-60
PHYSICIAN'S NAME (Type): R. J. Gore, M. D. — Salisbury, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-19-60
22c. NAME OF CEMETERY OR CREMATORY: Denton
22d. LOCATION (City, town, or county) (State): Denton, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: J. E. Boulais — ADDRESS: Greensboro, Md.
24a. REC'D BY REGISTRAR DATE: FEB 23 '60
24b. REGISTRAR'S SIGNATURE: Arthur S. Kimmey

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58